

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 153515	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 11/04/2013
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH ADULT DIALYSIS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 N CAPITOL ST INDIANAPOLIS, IN 46202		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{V 000}	<p>INITIAL COMMENTS</p> <p>This visit was a follow-up to the ESRD federal complaint survey that was conducted on 9/18-25/13.</p> <p>Complaint #s IN00136608 and IN00136200 - Substantiated: Federal deficiencies related to the allegation were cited. Unrelated deficiencies were also cited.</p> <p>Survey date: November 4, 2013</p> <p>Facility: 003229</p> <p>Medicaid Vendor: 200383830</p> <p>Surveyor: Susan E. Sparks, RN, PHNS</p> <p>Four Conditions for Coverage and 27 standard level deficiencies were corrected with this survey.</p> <p>Indiana University Health Adult Dialysis Center is in compliance with the Conditions for Coverage 42 CFR 494.30: Infection Control, 494.60 Physical Environment, 494.110 Quality Assessment and Performance Improvement, and 494.150: Responsibilities of the Medical Director during this survey.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN November 5, 2013</p>	{V 000}			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.